ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

COURSE ROSTER

(Check one)

____Official **____Addendum**

Program Name: _____ Certificate Number: _____

Course Name: _____

Location of Course: _____

Course Start Date: _____ Course End Date: _____ Completion Date: _____
(If other than end date)

Program Director: _____ Lead Instructor: _____

Medical Director: _____

Name	Home Address	Social Security Number	Cert. No. Exp. Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

Course Roster Continued

Name	Home Address	Social Security Number	Cert. No. Exp. Date
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			

I attest that the students listed on this course roster have met all course requirements in A.R.S. Title 36, Chapter 21.1 and Title 9, A.A.C. Chapter 25 and that all information submitted is true and accurate.

Signature or electronic signature of the Training Program Director: _____

Date of signature or electronic signature: _____